

Supplemental Forms



If you are asking for lost wages or counseling because of the crime, this booklet has the forms that we will need in addition to your application.

****For Lost Wages:** If you have been unable to work for at least two weeks in a row, we need both of these forms completed and returned:*

***Physician's Disability Report** - This form is for your doctor to tell us how long you will be unable to work.*

***Employer's Report** - This form is for your employer to tell us the average weekly amount you are paid and how much time you have missed from work.*

**If you must miss work because it is medically necessary to care for the victim, then you may be able to get Lost Wages payments.*

***For Mental Health Counseling:** There is also a form for your counselor (who must have a professional license) to fill out if you need mental health counseling because of the crime.*

***Mental Health Counselor's Report** - This form is for your counselor to tell us about your counseling and how many visits you need.*

Your well-being is our main concern. Please call us to discuss your options and any questions you have!

Take or mail these forms to your doctor, employer, and/or counselor. This will help us process your lost wages or counseling payments, if you qualify for them.

What needs to be done with the forms in this booklet

This booklet has three forms, called “reports,” that are to be torn apart and given to your doctor, employer, or mental health counselor:

- ♦ *Physician’s Disability Report*
- ♦ *Employer’s Report*
- ♦ *Mental Health Counselor’s Report*

If you need us to help pay for your *Lost Wages* because you have been unable to work for two weeks in a row or more, please tear out both the *Physician’s Disability Report* and the *Employer’s Report*.

Lost Wages

Give the *Physician’s Disability Report* to the doctor who is treating your injuries from the crime. He or she will tell us about your injuries from the crime. Your doctor will also tell us how long you must stay out of work.

Give the *Employer’s Report* to your personnel or payroll office if your workplace has one. We will need to know your average weekly wage. Then we may be able to award you about two-thirds of what you usually earn, based on Workers’ Compensation rates.

Loss of Support

If you need counseling because of the crime, give your counselor the *Mental Health Counselor’s Report*. He or she will tell us about your counseling needs. We consider counseling as part of your health care. The counselor must have a professional license in order for us to pay for your visits. SOVA can pay for either 20 sessions or 180 days of counseling, whichever amount you use. We pay by a set fee schedule.

Counseling

As soon as the completed forms are returned from your doctor, employer, or counselor, we can start the payment process for your lost wages and/or counseling (up to a total of \$15,000), if you qualify for them.



Mental Health Counselor's Report

Rev. 6/06

State Office of Victim Assistance ♦ 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 ♦ Phone: (803) 734-1900 ♦ Fax: (803) 734-1708

Refer to instructions and stipulations on reverse side.

Today's Date ____/____/____

Victim's Legal Name _____ Claimant (if a different person) _____

Social Security No. ____/____/____

Crime Date ____/____/____

Is the trauma and the treatment a direct result of this crime? YES ____ NO ____

Presenting Complaint _____

Diagnosis of Record _____

Description of injury and/or psychological trauma as related to victimization _____

HEALTH INSURANCE CARRIER

Policy # _____

() _____

Company Name _____

Telephone No. _____

Mailing Address or P.O. Box _____

City/State/Zip Code _____

Authorized Signature of Treating Therapist/Counselor

Printed Name of Payee

() _____

Telephone No./Extension

License Type and No.

Mailing Address

City/State/Zip Code

Supervisor's Signature

License Type and No.

Date

NOTE: SOVA does NOT act as guarantor for any services rendered.

Mental Health Counseling Reimbursement

DEFINITION

Mental health counseling for compensation purposes means “the assessment, diagnosis and treatment of an individual’s mental and emotional functioning that is required to alleviate psychological trauma resulting from a compensable crime.” This definition is in accordance with state statutes that afford reimbursement for medical expenses on behalf of eligible victims.

SUPPORTING DOCUMENTS REQUIRED

- ◆ Mental Health Counselor’s Report form must be completed by the victim’s counselor and must certify whether the psychological trauma being addressed is a direct result of the crime.
- ◆ **Itemized bill in the victim’s name** from the mental health counselor detailing the actual dates of service, type provided (i.e. individual, group, medication management), the CPT code assigned, and the amount charged.

LICENSED PROFESSIONAL

This office provides reimbursement for trauma treatment (generally considered as a medical expense) only when such service is rendered by a professional who is licensed in a specialty which includes mental health counseling; this includes medical doctors, psychiatrists, and psychologists.

LIMITATIONS

- ◆ Reimbursement amount is based on a fixed fee scale determined by this office.
- ◆ Financial aid is limited to any number of sessions within 180 days of the first charged visit (up to the allowable recovery amount including other benefits) or 20 sessions scheduled as needed for resurfacing trauma, whichever is greater.
- ◆ This office pays the outstanding balance from bills not fully covered by existing medical insurance; if a victim has private or public medical insurance, bills must first be filed with applicable companies/ carriers before submission to this office for possible payment.



Physician's Disability Report - Lost Wages Rev. 6/06

State Office of Victim Assistance ♦ 1205 Pendleton St., Brown Bldg. Room 401, Columbia, SC 29201 ♦ Phone: (803) 734-1900 ♦ Fax: (803) 734-1708

An application for assistance has been filed with our office for the crime victim listed below.
Please complete this form and return it to us as soon as possible; a fax is acceptable.

Full name of injured patient _____

Social Security No. ____ / ____ / ____

Date of Birth ____ / ____ / ____

Date the patient was first seen by you ____ / ____ / ____

Diagnosis: _____

Briefly describe extent and location of injuries: _____

Did the patient sustain any disability? Yes No (Please circle one.)

If yes, is the disability solely a result of this injury? Yes No (Please circle one.)

Please explain: _____

Patient will be totally unable to work from ____ / ____ / ____ through ____ / ____ / ____

Patient will be partially unable to work from ____ / ____ / ____ through ____ / ____ / ____

Has the patient been discharged from your care? Yes No (Please circle one.)

Has payment been filed with any of the following?

Medicaid Yes No Policy # _____

Medicare Yes No Policy # _____

Workers' Compensation Yes No

Other insurance or program Yes No Company or Agency _____

Address _____

Type or print physician's name _____ Phone (____) _____

Signature of physician _____ Date ____ / ____ / ____

Address of physician _____

SOVA Claimant/Applicant filing for benefits *(print full name)* _____

Job Type _____ Social Security No. ____ / ____ / _____ Date of Birth ____ / ____ / _____

Employer: An application for assistance has been filed for the person listed above.
Please complete this form and return it to SOVA as soon as possible; a fax is acceptable.

Date the above person was first employed by you _____ / _____ / _____

Date he/she was first absent due to crime related injuries _____ / _____ / _____

Date he/she returned to work part time, if applicable _____ / _____ / _____

Date he/she returned to work full time _____ / _____ / _____

Date he/she was terminated, if no longer employed by you _____ / _____ / _____

Insurance Type and Policy No.

Health/Medical # _____ Disability # _____

Was this employee compensated for time absent from work? _____ *If so, how much?* _____

Daily Work Schedule: from _____ am/pm to _____ am/pm

Average work hours per week _____ *Average overtime per week* _____

Average hourly wage _____ *Overtime hourly wage* _____

Gross salary per week _____ *Average commissions per week* _____

Employer _____ Address _____ Phone No. (____) _____

Person Completing Form *(print)* _____ Signature _____

***Title* _____ *Date* _____ *Comments?* _____**

****Further documentation may be required to receive lost wages/support, i.e., W-2, pay stubs, or tax returns. Wages will be offset by other sources such as annual or sick leave, social security or disability.**